

proved the acceptability and effectiveness of these strategies for quality improvement and care management strategies in a range of healthcare settings and patient populations.^{6 7}

The IMPACT study shows that the strategies for quality improvement and care management proved effective in younger adults with depression can be extended to older people. Acceptability of the IMPACT treatment programme was high, and clinical benefits were at least as large as those seen in younger or mixed age samples. Clearly, depression is not an inevitable consequence of ageing, functional limitation, and chronic illness. The belief that older people have “good reason to be depressed” has sometimes led to misplaced nihilism regarding treatment for depression.

These data show that relatively modest levels of continuity of care and of maintenance treatment yield important and sustained benefits. Initial evaluations of collaborative care for depression showed that short term interventions produced only short term benefits.⁸ The IMPACT stepped care programme allowed for varying intensity of long term treatment. Follow-up and monitoring for most patients who were responding well to initial treatment was provided through brief monthly phone calls from their depression care manager (usually a primary care nurse). Those not responding were offered augmented treatment and consultation with a specialist. Patients in the intervention group maintained important clinical gains through the 12 month intervention period and the following year.

These findings suggest that the value of improving care for depression should be judged over a period of two years or more. The largest investments in improved treatment are made in the first three to six months, but the maximal benefits do not occur until six

or 12 months. When you're measuring the number of miles travelled per gallon of gas, you have to include the time that you spend coasting (an analogy useful beyond US and UK readers).

It is refreshing that the paper by Hunkeler and colleagues does not end with the customary call for additional research. The evidence base is now sufficient for the emphasis to shift from research to dissemination and implementation.

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The incidence of gastroschisis

Is increasing in the UK, particularly among babies of young mothers

Gastroschisis is the evisceration of the fetal intestine through a defect in the paraumbilical anterior abdominal wall with herniation of gastrointestinal structures into the amniotic cavity. Babies born with this condition are more likely to be born prematurely and to have had poor fetal growth. The anomaly requires immediate postnatal surgery, which has a good outcome in more than 90% of cases.¹ It is a distressing condition for parents, however, and often requires a prolonged stay in a paediatric unit.

Ten years ago our group reported in the *BMJ* that the national system for notifying congenital malformations (collated by the Office for Population and Census Surveys, now called the Office for National Statistics, ONS) showed an increasing trend in the number of babies born with gastroschisis in England and Wales between 1987 and 1993.² No such marked increase was apparent for other congenital anomalies such as exomphalos.

Gastroschisis was associated with a lower overall maternal age: the incidence among mothers aged under 20 is 4.71 per 10 000 total births compared with

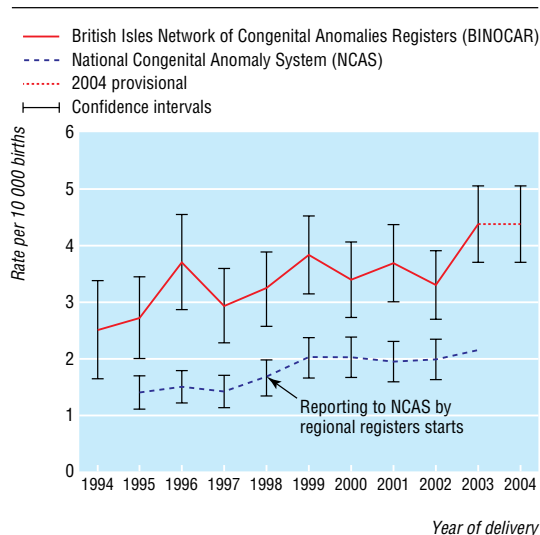
0.26 per 10 000 total births to mothers aged 30-34. Furthermore, the incidence of gastroschisis was markedly higher in the northern regions of the United Kingdom (1.55 per 10 000 total births) than in the southeast (0.72 per 10 000 total births).²

The notification system is voluntary, however, and under-notification and misclassification of malformations may therefore be considerable, leading to under-ascertainment.³ This also favours over-notification of very visible anomalies such as gastroschisis while probably grossly underestimating non-visible lesions, such as heart defects. Nevertheless, even gastroschisis seems to be underestimated in ONS statistics.^{4 5}

In contrast, regional registers for congenital anomalies aim to include all data from abortions, fetal loss, and infant deaths, as well as cross referenced information from paediatric surgical units. Such data sources have consistently shown better and more complete registration of congenital anomalies and have confirmed both an increasing incidence of gastroschisis among babies of teenage mothers and an overall increase year on year.⁶ This discrepancy between

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Number of reported cases of gastrochisis between 1994 and 2004. Reproduced with permission from the Department of Health

different register types has been well described.⁷ The UK's chief medical officer has expressed concern about the rising incidence of gastrochisis (L Donaldson, personal communication, July 2005) and has highlighted the importance to public health of rigorously compiled and centrally funded regional registers in providing information on congenital anomalies.⁸

Recent data from the British Isles Network of Congenital Anomaly Registers (BINOCAR) confirm the increasing incidence of gastrochisis—from 2.5 per 10 000 total births in 1994 to 4.4 per 10 000 in 2004.^{8,9} Among babies of women aged under 20 the incidence of gastrochisis increased from 8.9 to 24.4 per 10 000 total births. In addition, the incidence in some registers is four times as high as in others across different regional registers—for example, the Welsh register indicates an incidence of gastrochisis of 6.2 per 10 000 total births, whereas the rate in North West Thames was 1.6 per 10 000.

The observed increasing incidence of gastrochisis over time seems to be associated consistently with lower maternal age.² Gastrochisis probably does not

have a genetic cause because it occurs sporadically, with a relatively low recurrence rate. The most likely cause is early interruption of the fetal omphalo-mesenteric arterial blood supply. This may be associated with periconceptional tobacco smoking and use of recreational drugs such as alcohol, marijuana, and cocaine.^{10,11} The evidence for these associations is, however, only tentative and needs confirmation by carefully controlled cohort or case-control studies.^{12,13} Along with data from regional registers, such studies may lead the way to understanding the pathogenesis of this distressing condition and thus preventing it.

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Detention of refugees

Australia has given up mandatory detention because it damages detainees' mental health

More than 7 million of the world's 17 million refugees remain "warehoused" under conditions of confinement,¹ raising serious human rights issues about the treatment of people fleeing oppression. The British policy of expanding detention centres for asylum seekers adds to this concern, making it timely to consider what lessons might be learnt from Australia's recent reversal of its mandatory detention policy.

In 2002 Australia stood alone in introducing indefinite, non-reviewable, mandatory detention for asylum seekers arriving by boat or without valid entry

documents. Asylum seekers of all ages, including children, were held for years in remote detention centres. From the outset, the medical profession (clinicians, researchers, the Australian Medical Association, and specialist colleges) raised concerns that detention might adversely affect the mental health of traumatised refugees.² Clinical observations were supported by research conducted by an Iraqi doctor held in detention³ and by Australian specialists in refugee mental health.^{2,4} A recent study found that confined children and their parents suffered from a range of mental disorders largely attributable to detention.⁵ The